Improving Effectiveness in a Rural Medical Center: CEO's Story of his SEAM Journey

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Abstract

The Executive Leadership Team in a Wisconsin rural health care system (the Medical Center) decided to undergo the Socio-Economic Approach to Management (SEAM). This paper is the CEO's reflection on his journey through the SEAM process and his analysis of changes that happened in the organization.

Key words: SEAM, socio-economic approach to management, change management, rural healthcare, rural hospitals, culture change.

I am the CEO of a healthcare system in rural Wisconsin. Our Medical Center consists of a hospital and five community clinics that includes primary and specialty care. There are over 740 employees. Over the years, the Medical Center has strived to provide excellent patient care, but the challenges that face all rural health care facilities are significant. I came to see that to meet these challenges, and to survive fiscally, something had to change.

I knew that to be effective we had to simultaneously increase patient experience, improve the quality of services provided, reduce overall costs and increase organizational effectiveness. I knew the organization had to change something but did not know how and what had to change. At first, my intention was to focus on patient experience and quality. Later, I realized that the ultimate focus had to be on the organizational culture. The culture needed to be transformed to make the organization more effective. This paper is my story of how SEAM is helping employees transform the Medical Center culture.

Challenges in rural health care. The challenges of rural health care are different than those in urban areas. First, the population tends to be older, since younger patients migrate to urban centers. The older population by itself is not the problem. However, the patients of rural healthcare frequently have lower income and often are uninsured or underinsured. The rural population is more likely to live below poverty (United States Department of Agriculture, 2015). Because they live in remote areas, rural residents can have more difficulties to reach health care providers.

At the same time, it is difficult to recruit Primary Care physicians. Even though rural communities contain about 20% of America's population, less than 10% of physicians practice in these communities. Rural hospital closures continue due to economic challenges and the aggressive strategy of big entities to acquire smaller health care organizations in order to gain market share.

In 2015, the leaders of the Medical Center came up with wonderful goals. We wanted to be a financially thriving medical center with superior clinical outcomes and exceptional patient experience. We wanted to be the best place to work and practice medicine, and be a market leader in our region.

Those were great goals. I also knew that there were several factors that threatened our ability to achieve these goals. Externally, the nature of rural health care, and the morass of federal, state, and regional regulations were big challenges. These external factors pressured health care to reduce costs and increase effectiveness. We also had internal challenges. In the top leadership group, we lacked full agreement on the strategic vision. Organizationally, we had a "We vs. Them culture" – a culture of blaming rather than collaboration. As an organization, we lacked resources and bench strength. There was also a lack of cooperation among the medical group, the administration, and the staff. I concluded that we needed help, and began to look for something that would help us succeed. I needed some change that would help us overcome our external and internal challenges, achieve our organizational goals, alleviate our organizational problems, and sustain itself over time.

Choosing SEAM

I began to search for change methodologies. I was considering Lean, Six Sigma, Studer, and one day I came across the Socio-Economic Approach to Management, or SEAM. This method of organizational change originated in Lyon, France in 1973 and within the last decade, slowly began to spread in the USA.

Socio-Economic refers to the SEAM concept that an organization has to attend to both the human, or *socio,* side of the workplace as much as the financial, or *economic*, side of the workplace. Both are essential and yet most consulting methods, I have seen, aim primarily at the economic side of work. The problem is that while most organizations think they attend to the human side of work, they do not integrate socio and economic. I liked the dual focus on the economic and human side, it seemed very appropriate for the health care organization.

In terms of objects of change, most consulting approaches try to change organizational structures or employee behaviors. Structures can be rules and regulations, or organizational charts. Reengineering and downsizing are structural approaches. Changing behaviors involves getting people to work differently. Lean and Six Sigma are examples of behavioral change approaches. SEAM has a different approach.

According to SEAM theory, when structures and behaviors are not functioning as well as they might, there will be problems, which are called dysfunctions. Every dysfunction has a cost, and since these costs are not measured by traditional accounting, they are called *hidden costs*. The average hidden cost per person per year in the US is somewhere between $20,000 and $70,000, depending on the industry. SEAM works by first identifying dysfunctions and hidden costs, and then involving all the people involved to improve the processes to reduce dysfunctions and hidden costs (Conbere & Heorhiadi, 2011, 2015).

The SEAM change process has three components -- an intervention, learning about SEAM management tools, and personal coaching for all leaders. As a leader, I really liked the fact that I can have three interventions for the price of one. With one intervention, I could have increased departmental efficiency, trained managers and leaders, and coaching assistance for leaders who would be implementing changes.

Reasoning behind choosing SEAM. I decided that SEAM would be a way for us to go. There were several reasons behind my choice. First, SEAM has a rigorous approach with a deliberate pace and a 40-year track record of success. This fits well with the evidence-based mentality of health care and medical professions. Second, the SEAM change method involves the whole system. I did not want to have change happen only in one part of the organization, and later have the changes be corrupted by old ways of the rest of the organization. I liked the way SEAM engages front line employees, increasing their ownership of the change process. Third, the idea of addressing dysfunctions and discovering hidden costs was very appealing. I was curious to see how much money we lose due to systemic issues. Fourth, I liked the fact that SEAM was compatible with other approaches, such as Studer or Lean, as many of employees were familiar with or have tried those approaches before. And lastly, I was hoping for a natural (not imposed) process to change our culture.

The SEAM Process in the Medical Center

We started the SEAM process from the C-Suite. During the data collection phase, all leaders were interviewed, and a month later our consultants provided the Mirror Effect. The Mirror Effect was shocking – it was a recitation of our quotes about the problems, both in the organization and our leadership team. We were overwhelmed – and not because we did not know about these problems. The shocking factor was the number of dysfunctions, categorized in six different areas. Being good leaders, we wanted to fix all the problems right away, but we were told not to even think about fixing the symptoms.

A month later in the Expert Opinion, the consultants provided their insights into what we did not mention, and into the root causes of our dysfunctions. In SEAM theory, there are five root causes that create organizational dysfunctions (see figure 1). What I saw in the leadership team, and later in many silos of the medical center, is that people wanted to fix the problems quickly without thinking about what underlines those problems. For instance, if members of a

group do not listen well to each other, it is easy to decide "now we will listen better." That fixes the symptom, for a little while. The root of the problem could be lack of trust, which would indicate that building trust is needed, not a simplistic decision to listen better.

The concepts of root causes really resonated with me. I found it interesting that behind hundreds and thousands of problems in organizations there are only five root causes. They are: the lack of steering, lack of synchronization, lack of negotiation, lack of cleaning up, and poor information systems. Once I learned about the root causes, whenever and wherever I heard people talking about problems, I could very quickly identify one or two root causes behind the symptoms that people treated as the problem. I often thought that if we could eliminate root causes in all silos, we would be very effective and prosperous.

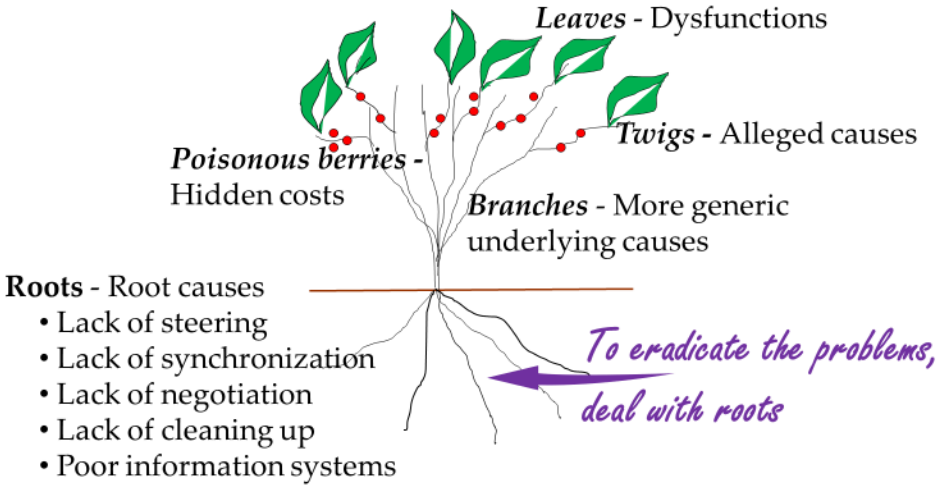

Figure 1. The roots of organizational dysfunctions, and the symptoms (branches, twigs, leaves, berries). Used with permission of SEAM, Inc.

For those who are not familiar with the root causes, here is a brief summary. Lack of steering relates to failure to align people and resources towards achieving organizational strategic goals. Lack of synchronization means that all the of parts of an organization do not work in harmony. Lack of negotiation happens when top-down autocratic management fails to engage employees. Lack of cleaning up is a common problem in organizations, in which when changes are made, old rules and previous processes are left in place. Poor information systems is when workers at all levels do not have the necessary information to do their work properly (Conbere & Heorhiadi, 2018).

The root causes were identified by the consultants as areas that needed correction, and shaped the improvement efforts which the consultants called *baskets*. These baskets contained

clusters of issues, which we had to improve, correct, or redesign. For example, some of our tasks in the C-Suite were to reduce dysfunctional communications, improve decision making, and develop our strategic vision.

Although the intervention process was difficult at the time, we gained knowledge and skills that made us better team players. The learning through reflection with coaching support made us all better leaders. I wish I would have experienced this socio-economic approach decades ago, before all the bad habits developed.

Cascading change through the organization

Later, as the C-Suite began to work on projects, similar interventions began in the Business Office and Diagnostic Imaging department. These interventions followed the same rigorous process, although there was a difference, in that these interventions included a calculation of hidden costs. Hidden costs were not calculated at the leadership level because the more obvious hidden costs are on the operational level.

In the fall, one clinic and the Surgery Department had interventions. In the next year we added another clinic, Quality, HR and Education, IT, Facilities, and our specialty clinic. Figure 2 shows how change cascaded through different silos. To date, we involved one fourth of all members of the organization. I can see that meaningful and long-lasting change of the whole organization is not a quick process. One has to stay committed to change, especially when there is a need to change culture.

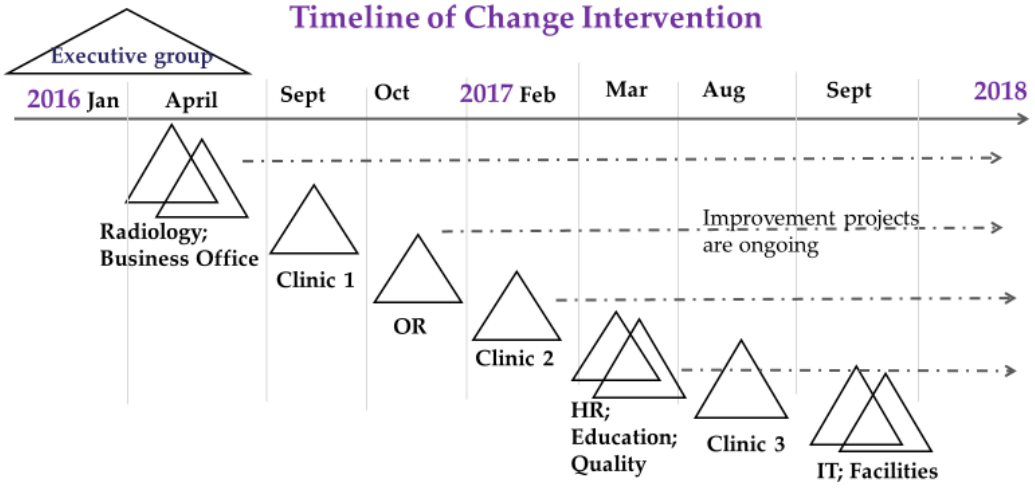

Figure 2. Cascading change through the organizational silos. Used with permission of SEAM, Inc.

Reducing resistance to change. One of the challenges in organizational change work is how to reduce the resistance to change. Too often, employees perceive that leaders make decisions about change that result in making the employees' work life harder. Their experience often supports this perception: leaders make changes without really listening to employees. Sometimes employees know things that leaders do not, so the changes are not effective. When changes are made without listening to the employees' experience, employees feel disrespected and lose trust in any change initiative and consequently leadership. Overcoming resistance to change was one of my concerns. I wanted people to be engaged, rather be resistant due to misperceiving the positive intentions of the leadership team. SEAM was very deliberate about reducing resistance to change.

Involving all employees. The SEAM process involves everyone in the change process. Everyone has a chance to be interviewed. In small departments, all employees were interviewed, in bigger ones, at least half were interviewed. Everyone was required to attend the Mirror Effect and Expert Opinion sessions, which can be difficult to arrange in a Medical Center. Department directors were accommodating people's schedules, so they could attend. Since we are a healthcare organization, and our focus is patients, we could not always have all employees of one department present at those sessions. We found a solution – repeating those session for those who could not participate in the first one. This way, everyone had the same information, and all information was on the table.

When we started the SEAM process, there might be some people who were ignoring the process or did not want to participate. However, the information about the process spread very quickly, and with later interventions, people were seeking the opportunity to come to these feedback sessions.

Many people wanted to be involved in the project teams – they wanted to make sure they are part of the improvement projects. Some people were on two, or even three projects. I was very pleased to see physicians being involved in or leading projects. We were building the change momentum. People were engaged and excited to improve things. Earlier I mentioned that SEAM focuses on reducing hidden costs and dysfunctions, and not on changing structures and behaviors. However, through the work on improvement projects, behaviors and structures happened naturally and not because someone proclaimed that. Some projects resolved in changing structures (buying new equipment or establishing new processes) based on hidden costs data.

Eliminating blame. As we identified different dysfunctions, we made it clear that everyone tries to do their best at work. Dysfunctions are caused when the system is not working well. Thus, the task is to change the system, not to blame individuals. I must say this was not easy. In modern workplaces, very often problems are attached to people. In our organization, it

was true for many years. I realized that we needed to change this blaming, and finally through the SEAM process, we received the tools and instruments that slowly started to transform blame into productive problem resolution.

Part of work on elimination blame was changing employee perception of us as leaders. It is not a surprise that employees historically inherit some perception of leadership. Regardless of what new leaders do, employees still keep the old beliefs about leadership. The fact that leaders in the C-suit underwent the intervention themselves demonstrated to the rest of the organization that leaders also needed to change. I was present at every Mirror Effect and Expert Opinion session in other departments and I shared with employees that we, leaders, also had our own Mirror Effect and Expert Opinion. I tried to be transparent about our commitment to change without blame, about our dysfunctions, and about our work to improve.

Intermediate Results, Two Years Later

To date, we have had interventions in 10 departments, not counting the leadership group. The table 1 shows the amount of hidden costs in these departments. To say the obvious, hidden costs have different forms. For example, it can be loss in the form of cash that was not collected, or in the form of the value of wasted time, or in the form of cash lost due to missing opportunities.

Table 1.
Calculated hidden costs in departments of the Medical Center

Unit	**Overpaid, $**	**Wasted time, $**	**Wasted money, $**	**Missed productivity**	**Non-development**	**Total, $**
DI	19,141	529,585	3,100			551,826
Business Office	38,977	1,900,136	805,128			2,744,241
OR	3,840	235,395	137,555	1,648		378,438
Clinic1	284,326	82,746	56,351	61,391	295,837	780,651
Clinic2	20,840	328,722		298,948		648,510
Employee			3,045			567,942
Quality		154,897	10,563			165,404
Clinic3	2,394	508,647	31,971	507,674		1,050,686
IT	4,905	358,378				363,283
Facilities	10,089	40,622	17,887	50,280		118,878
Total, $	384,512	4,703,969	1,065,600	919,941	295,837	**7,369,859**

In collecting data or measuring an impact of the intervention, SEAM uses a combination of financial, quantitative, and qualitative data. Many organizations tend to only look for the financial return on investments, or ROI, missing on the other two. Taking quantitative and qualitative data into account, it is easy to understand value on investment or VOI (Hamre, 2017).

We remeasured hidden costs in the first two departments a year after beginning the interventions. We already know, based on the improvement projects these departments are doing, that hidden costs will be reduced even more in the next year. Table 2 shows savings in these departments.

Table 2.
Calculated hidden costs a year later in 2 departments of the Medical Center

	Year	**Overpaid, $**	**Wasted time, $**	**Wasted money, $**	**Total, $**
Business office	**2016**	38,977	1,900,136	805,128	2,744,241
	2017	21,116	1,131,292	773,061	1,925,469
Savings		*17,861*	*768,844*	*32,067*	***818,772***
Diagnostic Imaging	**2016**	19,141	529,585	3,100	551,826
	2017	19,141	424,087	2,500	445,728
Savings		*0*	*105,498*	*600*	***106,098***
Total savings, $		17,861	874,342	32,667	**924,870**

Overcoming magical thinking. One of the biggest value from our investment in SEAM came from recognizing and reducing magical thinking. According to Conbere and Heorhiadi (2016), magical thinking is a delusional, and often unconscious, belief that one can do the impossible, which is very common in organizations. The more I worked with SEAM, the more I saw that magical thinking was rampant in our organization. I saw that the employees were not aware how their magical thinking was harmful to them and destructive of organizational productivity. They were committing to doing things without having the right resources, skills, or time. While their passion and commitment were commendable, trying to complete the projects using magical thinking led to more dysfunctions across the whole organization.

Improving leadership. The departments and clinics, through the SEAM process, became increasingly aware that a common problem in healthcare organizations is the lack of management and leadership skills. Physician or nursing leaders have not always been taught how to be good, or rather effective, managers and leaders. Mid-level managers and supervisors often rose through the ranks without ever learning what it means to be a good manager.

Recognizing the need for skilled leadership, we began the Nursing Leadership Academy for 15 nursing managers. A six months program is designed to provide basic knowledge about management to nursing leaders from our medical center. In the fall 2018, we plan to start a year-long Physicians Leadership Academy for physician leaders from our organization and outside healthcare systems. The focus on management knowledge and leadership skills was supported by the SEAM process and is based on theory that in sustaining change, mid-level management plays a critical role.

Change in culture. When we started, some employees were skeptical about change. They did not trust us, the leaders, to be consistent or fair in a change process. Many of them learned to live in a culture of blame. When something went wrong, the tendency was to find out whom to blame. This is why employees expected leaders to blame the one who is at fault. As departments began their SEAM work, the consultants repeatedly iterated the rules: "No one is blamed" and "Fixing the causes, not symptoms'" Employees were encouraged to learn, negotiate, and try new approaches. Their curiosity about how to improve the workplace increased. The outcome has been increased trust in leaders, and willingness to take risks for the improvement of the Medical Center.

As SEAM progressed, employees became more engaged. They participated in creating the changes. Now employees are much more skilled in resolving issues and differences through negotiation. Many have led change projects or been members of change projects. In fact, employees who went through SEAM can recognize people who are familiar with SEAM and who are not. They say that people who went through SEAM are more cooperative, willing to negotiate and resolve the problems more constructively. People who have not been involved in SEAM yet, tend to defend their turf and redirect blame onto others.

The reason the culture is so difficult to change is because culture is a software of mind (Hofstede, Hofstede, & Minkov, 2010). The culture changes when people change the way they think about leadership and about how things work in the organizations. It is important to be patient here. However, I have witnessed subtle changes in people's attitudes and beliefs. Table 3 shows some examples of change in beliefs.

Table 3.
Examples of change in belief systems through the SEAM process.

Old belief system	**New belief system**
"Nothing will change. This is the way we worked for ages."	"We can change the way we work. It depends on us."
"If I did something wrong, I will be blamed. Thus, I am not going to say anything."	"If something went wrong, I need to share this, so we all together can find a way to improve things."
"Communication is awful here. I do not know what is happening."	"I am part of communication loops in the organization. My role is to make sure these loops work."
"We are so busy - we do not have time to plan or to meet."	"We cannot afford not to meet and redesign things."

Value on investment. I know that we still have a way to go. I am very excited to see the results we have achieved so far. Now I understand why SEAM is evidence based. SEAM has a way to document many different changes that occurs through the intervention process. Table 4 summarizes some of our achievements in financial, quantitative and qualitative categories. I say *some* achievements, because other silos are still in process of gathering their data on the moment of writing this paper. I know that a lot of good things are happening all over the Medical Center.

Table 4.
Value on Investment from SEAM Intervention in the Medical Center

Financial Outcomes	**Quantitative Outcomes**	**Qualitative Outcomes**
Reduced hidden costs by **23%**	Reduced wasted time	Increased engagement of employees
Savings of **$924,870**	Reduced turnover	Increased employee competencies; management & leadership skills of managers
	Reduced A/R Days **- 97 → 66**	Improved morale & culture
	Increased Days Cash on Hand - **63 → 105**	Reduced magical thinking
	Reduced Days of Debt - **27 → 15**	Improved patient services & patient experience
		Reduced risks

When I look at the value received for our investment in SEAM, I wonder why wouldn't any leader want to invest in or lead sustainable change? Why wouldn't a leader want to reduce dysfunctions? Why wouldn't a leader create an environment that respects and values all team members? Why wouldn't a leader create an organization that can thrive? I know we made the right choice.

Conclusion

I believe that no matter how well an organization is run, there is always an opportunity to become even better. I realized this by learning about SEAM and challenging myself to be vulnerable and open to an organizational transformation. What I have learned through the SEAM journey is that there is no shortage of dysfunction. Dysfunctions are everywhere. That also means everywhere there are opportunities to improve.

After the leadership team went through change, we continued to cascade SEAM down through multiple functional silos of the organization. I was present at every feedback session in each silo, which gave me a wealth of information I did not know before. I have also witnessed a

general consistency in baskets that tried to address the same root causes of many different problems. I saw how employees wanted to be engaged in improvement projects because they knew it would improve their everyday work. Instead of feeling hopeless, they became active in reducing dysfunctions in their own departments and across other departments in the organization. As result, involvement in the change process gave employees an opportunity to develop. Since there was a lot of untapped potential in employees, the change process allowed to uncover this potential in different form and manner. This released potential triggered change throughout the organization.

SEAM is a long-term commitment. There is no quick fix. Those who believe that sustainable and radical changes may happen in a few months, may be delusional. It will take 3 to 5 years for change to cascade throughout an organization to ensure it becomes part of the cultural fabric. I witnessed the outcome of SEAM in my organization - culture change. This culture change was not imposed; it happened not because someone proclaimed it. It was an iterative process -- people began to believe they are heard and respected. And because they felt heard and respected, they took ownership of change, they took on new initiatives, and modeled change for those who still did not go through SEAM intervention. I can say that SEAM healed the workplace and created a more vibrant organization.

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